



Islamic Republic of Afghanistan Ministry of Public Health

Prison Health Services Strategy 2.0

Table of content

Foreword	4
1. Introduction.....	5
1.1. Structure and history of prisons in Afghanistan.....	6
1.2. The 2008 PHS reform in Afghanistan.....	6
1.3. Prison Health Services development 2009-2015	8
1.4. Prison Health Services Strategy 2015 – 2020	9
2. Components of the PHS Strategy	10
2.1 Prevention	10
2.2 Epidemiological surveillance.....	11
2.3 Curative care	11
2.4 Detention-specific issues.....	12
2.5 Essential drug supply	12
3. Annex: Key monitoring and evaluation indicators	12

Acronyms

BHC	Basic Health Centre
BPHS	Basic Package of Health Services
CHC	Comprehensive Health Centre
DDR	Drug Demand Reduction
EPHS	Essential Package for Hospital Services
EPI	Expanded Programme of Immunisation
GCMU	Grants and Contract Management Unit
GDPDC	General Directorate for Prisons and Detention Centres
HMIS	Health Management Information System
ICRC	International Committee of the Red Cross
M&E	Monitoring and Evaluation
MH	Mental Health
Mol	Ministry of Interior
MoJ	Ministry of Justice
MoPH	Ministry of Public Health
MoU	Memorandum of Understanding
NACP	National AIDS Control Programme
NTP	National Tuberculosis Programme
PHD	Provincial Health Director
PHS	Prison Health Services
PHSWG	Prison Health Sub Working Group
PiC	Pul-i-Charkhi
SEHAT	System Enhancing for Health Actions in Transition
SM	Strengthening Mechanism
WB	World Bank



**Islamic Republic of Afghanistan
Ministry of Public Health**

Foreword

The Ministry of Public Health (MoPH) of the Islamic Republic of Afghanistan is very pleased to present this newly revised Second Version of the Prison Health Services Strategy (PHSS) 2015/1394.

Prisoners and juveniles are part of general community of Afghanistan. Based on the laws they are kept for a specific period of time in detention places. All rights «except free movement» of the prisoners and juveniles detainees are in place. Because of that the MoPH created prison health department according to its policies and strategies. The MoPH developed PHS strategy and package in order to provide health services to this vulnerable group of people.

This revision is based on the increased in the number of prisoners, Prisoners' health needs, and lessons learnt from the implementation of the first version of the PHS Strategy.

Luckily the prison health department of the MoPH, relevant departments of the MoPH, respective departments of the ministries of interior and justice, international bodies involved in the prison health activities, and representatives from implementing NGOs revised the PHS Strategy.

In the second revised version there is more focus on the quality of services and well usage of resources. In the current version the prison health facilities are divided into four categories, while in the first version there were three categories only.

In the second version:

1. A Prison Basic Health Center (PBHC) will be available in the prisons having 50-499 prisoners.
2. A Prison Comprehensive Health Center (PCHC) serves in prisons holding 500-1499 prisoners.
3. A Prison Comprehensive Health Center Plus (PCHC+) serves in prisons with more than 1500 prisoners.
4. A hospital will serve for prisoners in Pul-i-Charkhi Central Prison.

Prison Health Services are part of Basic Health Services of Afghanistan. The implementation channel of the PHS is the same as BPHS. Health needs of the prisoners are the same to the general population with the difference of higher prevalence and incidence of the diseases in the prisons. Mental problems are more present in the custody system in the country. There is a special focus on mental health services in the prisons and Juvenile Rehabilitation Centers (JRCs). There is a very closed contact among prisoners and it increases risk of spread of communicable disease among the prisoners. Diseases prevention is a back bone of prison health services.

One of the responsibilities of the MoPH is to provide basic health services to all Afghans. The PHS package is prepared to insure that all Afghans have access to basic health services. In the other hand having active health facilities in the prisons will decrease referral of prisoners from the prisons to the health facilities working in the general community. The last will help easy access of the prisoners to the health services.

I would like to express my appreciation for the tremendous efforts provided by the PHS department and members of the PHS revision committee. The MoPH

appreciates the continued financial support for the PHS implementation, and is especially grateful to European Union and EPOS Health Management for providing funding and technical assistance for the elaboration of this version of the PHS Strategy.

Dr. Najia Tariq
Deputy Minister for Health Care Services Provision
Ministry of Public Health
Kabul, Afghanistan
July 2015

Handwritten notes in blue ink: "2/9" circled, "3.5.1394" written vertically, and "7/8" written horizontally across the text.

1. Introduction

This second version of the Prison Health Services (PHS) Strategy for Afghanistan replaces the one adopted by the Ministry of Public Health (MoPH) and the Islamic Republic of Afghanistan in 2009; it is based on nearly six years experience with PHS – which are at present still being rolled out.

1.1. Structure and history of prisons in Afghanistan

The responsibility for managing the Afghan penitentiary system passed from the Ministry of Interior (Mol) to the Ministry of Justice (MoJ) in 2003, and back to the Mol early in 2012. Within the Mol, the General Directorate for Prisons and Detention Centres (GDPDC) manages the detention facilities for adults; the Juvenile Rehabilitation Department, under the jurisdiction of the MoJ, manages the ones for juveniles.

Places of detention for adults include, at three main levels:

1. District detention facilities
2. Provincial Central Prisons
3. Central Prisons of Kabul

Each district has a place of detention; these, however, are not supposed to be used as long-term detention facilities. The district detention facilities rely on the local health structures for the provision of health services, if the need arises.

Each Provincial Capital has a Central Prison, of which there are 34 in Afghanistan¹. The number of their inmates ranges from a couple of dozens to over 3'000, including women, who are often accompanied by their small children. The Central Prison of Pul-i-Charkhi (PiC) in Kabul serves both as a detention centre for Kabul and a referral prison for certain categories of detainees from the provinces. PiC holds currently (beginning 2015) almost 8'000 detainees; the total detainee population in Afghanistan under Mol jurisdiction is around 30'000.

In all 34 provincial capital cities, juvenile detainees (numbering between 1'200 and 1'500 in the whole of Afghanistan) are held in separate Juvenile Rehabilitation Centres. In 2015, more than half of these facilities host 20 or more inmates. A special place of detention is Badam Bagh in Kabul, where the female prison of the Mol and the Juvenile Rehabilitation Centre of the MoJ are located next to each other.

The GDPDC has 102 health positions in the provinces², of which 86 currently filled; the central health office in Kabul consists of a total of 11 positions, of which four are health professionals. The Juvenile Rehabilitation Department of the MoJ relies entirely on the provision of PHS by the MoPH.

1.2. The 2008 PHS reform in Afghanistan

Health problems in prison reflect and magnify health problems present in any country; prisoners tend to have poorer health as a result of personal circumstances, lifestyle or environment. Prisons present also an unhealthy environment; poor

¹ Though Nuristan has no permanent prison

² of which 20 filled with civilians

conditions of detention may exacerbate health decline, disease transmission (tuberculosis and HIV/AIDS, among others), mental illness and substance abuse. Owing to the constant and intimate links with the community, prison health has therefore to be considered as an integral part of public health. WHO recommends that *“political support for healthier prisons should be based on the recognition that:*

- *good prison health is essential to good public health;*
- *good public health will make good use of the opportunities presented by prisons; and*
- *prisons can contribute to the health of communities by helping to improve the health of some of the most disadvantaged people in society.”*³

The PHS reform in Afghanistan, prepared in 2008⁴ and made official in 2009, consisted mainly in entrusting the responsibility for PHS to the MoPH instead of the detaining authority, owing to the inadequacies of health service provision by the latter. Similarly, experience in several countries of Europe had drawn attention to the problems that often arise if prison health services are provided separately from the country’s public health services. These include difficulty in recruiting professional staff and inadequate continuing education and training⁵.

Through the integration of prison health into public health (the prime objective of the reform), prisoners are recognized as temporarily incarcerated citizens. Accordingly, the WHO ‘Moscow Declaration on Prison Health as a Part of Public Health’ recommends that the government ministry responsible for prison health should, where possible, be the ministry responsible for public health services⁶. Countries that have taken this decision⁷ have shown that this allowed for significant progress in PHS. Among the encouraging results of such reforms are: resources for prison health have substantially increased and quality of staffing has improved; PHS has also gained through linking up with public health policies. Acceptable ethical standards and quality of care are easier to achieve if PHS are entirely independent of prison administrations; most importantly, opening PHS to public scrutiny is the most effective way of ensuring accountability and maintenance of standards⁸.

The reform of 2009 allowed for access to much higher levels of PHS funding through integration of PHS into the BPHS⁹ and access through SEHAT funding¹⁰.

³ WHO (2007) Health in prisons. A WHO guide to the essentials in prison health. Edited by: Møller L, Stöver H, Jürgens R, Gatherer A, Nikogosian H.

⁴ Based on the national legal framework cited in the PHS strategy 1.0, to which no changes were made since 2008

⁵ WHO (2007) Health in prisons.

⁶ WHO (2007) Health in prisons.

⁷ e.g. Norway, France, England, Wales and parts of Australia

⁸ For further details and references, see: Michael M (2014) Prison health as public health in Afghanistan? A policy analysis of the on-going reform process. Public Health 128 (5): 478-81

⁹ *“Increase equitable access to quality health services”. “Right to Health – We consider health as a right of each individual and are committed to creating conditions that support health and wellbeing without discrimination of any kind.” (GOVERNMENT OF THE ISLAMIC REPUBLIC OF AFGHANISTAN 2011 - STRATEGIC PLAN FOR THE MINISTRY OF PUBLIC HEALTH 2011-2015).*

And: *“The need to extend BPHS services to... persons residing in prisons is now explicitly mentioned” ... “Likewise, more specific recommendations are included on how increase access to services for difficult to reach populations, including ... prisoners. We invite all our partners to cooperate, under the stewardship of the MoPH, to make sure that all Afghans, living in remote villages or in prisons will be able to receive quality services through this newly revised BPHS” (Islamic Republic of Afghanistan, Ministry of Public Health (2010/13899. A Basic Package of Health Services for Afghanistan)*

PHS as an integral part of the BPHS and Afghanistan's health policy has been anchored in a number of other key health policy and strategy documents, implicitly or explicitly¹¹.

The Goal of the Prison Health Policy, paraphrasing the National Health and Nutrition Policy 2012- 2020¹², is: to improve the health and nutritional status of people of Afghanistan through a greater focus, among other marginalized people, on the population of people temporarily incarcerated. This goal is funded on a rights-based approach of the MoPH: "*All individuals—independent of gender, socio-economic status, age, race, religion, ethnicity and background—are entitled to quality health care; we are committed to creating conditions conducive to good health and well-being.*"¹³

1.3. Prison Health Services development 2009-2015

Between 2009 and the beginning of 2015, PHS have been rolled out in almost all provinces of Afghanistan (in a total of 30 of 34¹⁴): through NGOs implementing locally the BPHS (or, in a small number of cases, EPHS) in 27 provinces, through the MoPH/PHD in two provinces¹⁵ and in one by MoPH/SM¹⁶; in the remaining three provinces that SM covers¹⁷, it will implement PHS during the course of 2015. Whilst the GDPDC was hardly able to hire health professionals before, care is now provided by doctors, nurses and other specialists, at the same level as for the general population, within certain constraints (e.g. of limited premises). PHS are now provided by health professionals accountable to the MoPH, rather than by staff permanently assigned to prison and accountable only to the prison authority. This

¹⁰ "*In addition, financing will be made available for contracted services specifically for marginalized populations such as prisoners...*"
"*The proposed project*¹⁰ *will finance the BPHS in line with the newly revised BPHS guidelines, including new elements... and beneficiaries (e.g. ... prisoners) not covered by or that were not included in the original BPHS. Responsible Agency: Ministry of Public Health (MOPH)*" (World Bank. EMERGENCY PROJECT PAPER ON A PROPOSED GRANT IN THE AMOUNT OF SDR 65.1 MILLION (US\$ 100 MILLION EQUIVALENT) TO THE ISLAMIC REPUBLIC OF AFGHANISTAN FOR THE SYSTEM ENHANCEMENT FOR HEALTH ACTION IN TRANSITION PROJECT. Report No: 73645-AF, 2013.

¹¹ "*Deliverable 1.1.3: To increase the coverage of health services delivery by the Ministry of Public Health and to decrease the number of referral cases from the prisons to the health facilities outside the prisons through establishment of health facilities inside the prisons.*" (Islamic Republic of Afghanistan, Ministry of Public Health Human Resource Development Cluster, National Priority Program: Health for All Afghans, 2012

¹² "**2.3 GOAL OF MOPH:** *To improve the health and nutritional status of people of Afghanistan, with a greater focus on women and children, disabled, marginalized populations (my emphasis), and under -served areas.*" (Islamic Republic of Afghanistan, Ministry of Public Health (2012) National Health and Nutrition Policy 2012 – 2020)

¹³ "**Right to Health:** *All individuals—independent of gender, socio-economic status, age, race, religion, ethnicity and background—are entitled to quality health care; we are committed to creating conditions conducive to good health and well-being.*" (Islamic Republic of Afghanistan, Ministry of Public Health (2012) National Health and Nutrition Policy 2012 – 2020)

¹⁴ There is no permanent provincial prison in Nuristan

¹⁵ Kandahar and Herat, with ICRC support

¹⁶ in PiC, Kabul

¹⁷ Panjsher, Kapisa and Parwan

largely solves the well-known problem of ‘dual loyalty’ of prison doctors: it minimizes professional isolation, slipping standards and tipping the balance towards considerations of security when deciding on treatments.

Integration of PHS into the MoPH structure, its activities and programmes, has brought about a number of benefits. First, the significant enlargement of services and improvement of quality is being funded through SEHAT as part of donor support to the Afghan health system¹⁸. Secondly, the disease-specific programmes most relevant for prison health (i.e. MH, TB, DDR, NACP) are being implemented in prisons, as part of the BPHS and/or through vertical support (although some implementation gaps remain). Thirdly, health staff working in prisons participate in all training activities at central, regional and provincial level, fourthly, the extension of MoPH activities such as M&E and HMIS to prisons contributes to the perception and treatment of prison health as public health and at local level, prison health is open to public scrutiny through the implication of the PHD. Fifthly, the fact that the PHS implementers are active in other provision of health care in the same provinces gives them access to resources and services hitherto difficult to access (e.g. seconding a laboratory technician, facilitating hospital referral). Lastly, The PHS department of the MoPH supports the actors and provincial level and liaises other MoPH departments, with its main partner, the GDPDC and other key stakeholders, such as ICRC and key UN organizations. A central level, the Prison-Health Sub-Working Group (with all key stakeholders as members) continues to be active; in a number of provinces, these coordination activities are complemented by local Prison Health Coordination Committees, or discussed in the general Provincial Health Coordination Committees.

Among the shortcomings of PHS implementation so far are implementation gaps of various kinds: lack of suitable clinic premises in the prisons¹⁹, less-than-complete reach of all BPHS components to all prisons, incomplete coverage of screening upon entry, and funding gaps for the three provinces of Kandahar, Herat²⁰ and Kabul. Issues such as the release of very sick prisoners on humanitarian grounds remain to be solved by the MoJ. As expected, difficulties have arisen from the clash of different culture and objectives (public health vs. security) in a number of prisons. A certain duplication, at prison level, of PHS and remaining CDPDC staff (usually, not health professionals) has been observed, too, which is compounded by the lack of an MoU regarding PHS between the MoPH and the MoI, leaving both CDPDC and BPHS staff as unequal contenders²¹ for the same service.

1.4. Prison Health Services Strategy 2015 – 2020

The objective of the PHS Strategy is: to provide to all persons detained the same access to, and range and quality of care as to the general population in Afghanistan, through the integration of PHS in the provision of public health services. The target is to cover all places of detention at provincial level and above of the MoI (and the MoJ regarding juveniles) with services integrated into, and equivalent to the BPHS, with the necessary support of EPHS services. The one key indicator is the percentage of places of detention covered with these services, including all their specific components. A comprehensive mid-term evaluation is to be undertaken in 2017.

¹⁸ Although a few funding gaps still remain

¹⁹ Which is the responsibility of the GDPDC

²⁰ In these two provinces, ICRC has been bridging the gap

²¹ The former has the expertise and the latter the power

In order to reach the objective stated above, PHS needs to consolidate achievements and complement its coverage and service profile. Among the key challenges are:

- to find a more sustainable funding mechanism for the provincial prisons of Herat and Kandahar²²,
- to find more sustainable and integrated solutions for the remaining three prisons of Kabul²³,
- to increase cooperation and complementarity, at prison level, between MoPH PHS and CDPDC,
- to strengthen the PHS department, and, most importantly,
- to sign an MoU between MoPH and MoI along the lines of the original MoU signed with the MoJ in 2009²⁴.

The role of the Provincial Health Directorate will continue to be to provide stewardship oversight of prison health services within the province. This will include monitoring the implementation of the national PHS Strategy Package and ensuring that the implementation of related national strategies are integrated into PHS delivery where applicable. It is recommended that following the signature of an MoU between MoPH and MoI, local MoUs regarding PHS be signed at provincial level between the key actors (including the provincial hospital).

The following section lists the components of the PHS strategy 2.0, modified from the version 1.0 of 2009 in accordance with the new BPHS (2010) and based on experiences made and lessons learned in PHS over the last six years.

2. Components of the PHS Strategy

The PHS strategy 2.0 consists of five main elements, which correspond to the ones of the BPHS that are applicable to prison settings. The PHS will be implemented in accordance with the national programmes, protocols and guidelines, and will apply in all places of detention of the MoI and MoJ in Afghanistan.

2.1 Prevention

Health Promotion (Information, Education and Communication)

To be implemented by PHS staff both in the prison health facility and in the blocks/cells.

Public and personal hygiene (incl. eliminating ecto-parasites)

According to observations of the PHS staff, any condition potentially harmful to the prisoners' health must be reported to the prison director or staff, who are responsible for action. A hygiene kit should be distributed on quarterly basis to each detainee, juvenile and to children living with their imprisoned mothers.

Active case-finding for early diagnosis and prompt treatment

²² The channelling of USAID funds through SEHAT should provide an opportunity; or, as an alternative, WB funding through its Urban Health programme

²³ Welayat Tawqif detention centre and Badam Bagh (women and juveniles)

²⁴ Although the original one continues to be valid according to a letter signed by both Ministers on 12 January 2012

The PHS staff should visit the cells on a regular basis for this purpose. In conjunction with the previous two activities, this should reduce the risk of disease transmission and outbreaks.

Nutrition (balanced diet and nutritional hygiene)

PHS staff must help the logistic section of places of detention to plan the menus, taking into consideration the importance of a balanced diet. In addition, they should check the conditions of food-handling hygiene on a regular basis (from the kitchen to the delivering areas). Under-fives must be monitored for growth on a regular basis; the nutrition status of pregnant woman should be monitored.

Immunization

Women aged 15 to 45 and under-fives living with their mothers will be vaccinated by outreach immunization program from the nearest public health facility; NIDs and SNIDs programs will reach the under-fives living in prison.

Waste management

A suitable procedure for a proper waste management must be put in place.

2.2 Epidemiological surveillance

Initial medical screening of new detainees

Every new detainee must be screened at the arrival point of the prison. A medical file should be filled and filed for each. Detainees with suspected or confirmed highly communicable diseases (such as TB or scabies) should be medically isolated during the time they are treated. HIV, HBS, HCV, VDRL tests should be offered for the new arrivals.

Reporting as per HMIS

HMIS guidelines apply

Regular visits to the cells for active-case detection

As described above

2.3 Curative care

Primary Health Care

- Maternal and Newborn Care.
- Child Health
- Public Nutrition
- Communicable diseases treatment and control
- Mental health
- Disability and physical rehabilitation services
- Drug demand reduction services

B Specialized Care

Consultations – for diagnose and/or treatment – in the fields of ear nose and throat (ENT), surgery, ophthalmology, mental health, neurology, gynaecology, internal medicine, traumatology, dermatology, orthopaedic services, dental care and oral hygiene. If not possible in prison, these consultations (or, if need be, hospitalization) have to take place in a referral hospital.

2.4 Detention-specific issues

The health staff is trained to provide specific health care and act in accordance to national laws and international recommendations regarding specific prison health issues such as dual loyalty, medical ethics, hunger strikes, or ill-treatment.

2.5 Essential drug supply

The BPHS drug list is standard also for PHS, according to the level and service profile (roughly corresponding to BHC and CHC). Drugs are supplied free.

3. Annex: Key monitoring and evaluation indicators

The PHS department is to report twice yearly to the PHSWG on these indicators.

Key indicators listed according to subject:

PHS implementation:

- Number of central prisons where PHS is implemented according to standard (including all individual components)
- Number of PHS health facilities with a budget officially approved as part of the BPHS proposal
- Number and kind of disease-specific activities implemented
- Number and kind of trainings provided, number and kind of participants
- Number and kind of preventive activities
- Quality of files and records
- Medical screening for all new detainees: percentage covered
- Number of patients referred for specialist consultation or hospitalisation
- EPI for women and under-fives: coverage

Respect for detainees' right to health and health care:

- Activities that signify improvement of access to health care (e.g. active case-finding)
- All detainees, following their initial screening, have a medical record

Release of Detainees who are unfit for detention owing to serious ill-health:

- Number of eligible cases found
- Number of detainees released

Adequate staffing of Prison Health Facilities:

- Number and qualification of prison health staff
- Night presence of PHS staff in all prisons
- Number and kind of specialist consultations
- Availability of female health staff where needed
- Time available/ spent for consultations

Adequate provision of resources:

- Number and kind of essential drugs available in prison clinics

M&E, Supervision:

- Number and periodicity of PHS and other supervision visits
- Number of visits undertaken jointly by MoPH PHS and GCPDC
- Health staff satisfaction
- Prisoner satisfaction
- HMIS reports
- M&E visit reports

Conditions of detention:

- Epidemiological data
- Quality of detention conditions according to reports

Coordination

- Number and kind of special PHS coordination events
- Percentage of provinces where Provincial Prison Health Committees are active
- Number and kind of participants
- Frequency of Prison Health Sub Working Group meetings in Kabul; number and kind of participants